DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

June 10, 1988

ALL-COUNTY LETTER NO. 88-59

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY COUNSELS
ALL PUBLIC AND PRIVATE ADOPTION AGENCIES
ALL DSS ADOPTIONS DISTRICT OFFICES

SUBJECT: ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

The Federal Department of Health and Human Services (DHHS), Center for Disease Control (CDC), has issued guidelines to assist with the development of a uniform and systematic approach to problems associated with providing for the care, supervision, health or education of children known to be infected with Human Immune Deficiency Virus (HIV) which is the cause of Acquired Immune Deficiency Syndrome (AIDS). These guidelines are found in the publication entitled, "Acquired Immune Deficiency Syndrome (AIDS), Recommendations and Guidelines, November 1982 - November 1986." This publication was issued by the Public Health Services, DHHS, CDC, Atlanta, Georgia 30333.

In addition to their guidelines regarding general precautionary procedures, the CDC recommends that foster care placement agencies consider, before placement in foster homes, adding HIV screening to routine medical evaluations of children at increased risk of being infected with HIV. The State Department of Social Services (SDSS) concurs with the CDC's recommendation as long as the child's physician determines that HIV screening is medically appropriate, given the child's circumstances. This recommendation is consistent with SDSS regulations for Child Welfare Services (CWS) and Community Care Licensing (CCL) which require that foster parents, group home operators or licensees be provided with information including but not limited to the medical history and a history of infectious or contagious diseases of the child to be placed.

Section 199.27 of the Health and Safety Code (HSC) which was enacted by Assembly Bill (AB) 1951, Chapter 1427, Statutes of 1987 and which became effective January 1, 1988 permits the court to give consent for AIDS testing for a minor, regardless of age, who is a dependent of the court. Agencies should be aware that Civil Code Section 34.7 permits a minor over the age of 12 to consent to medical care related to the diagnosis or treatment of a sexually transmitted disease and thus allows these minors to consent to HIV screening. Some high risk minors over the age of 12 may choose to consent to

the HIV screening, or may have already been screened. If this occurs, agencies should include this information in the court petition and request the court to provide the order necessary to allow the disclosure of the results of the screening. If a high risk minor over the age of 12 has not been screened or will not consent to the screening, the agency should request the necessary orders for the screening and disclosure in the court petition. It is important to note that this consent may be obtained only when necessary to render appropriate care or to practice preventative measures. Placement agencies may secure court consent for testing by including a request for same as part of the petition for dependency under Section 362 or 369 of the Welfare and Institutions Code (W&IC), or at any subsequent time as long as the court has jurisdiction.

Adoption agencies should advise birth parents who are considering relinquishing a child from a high risk category to the agency for adoptive placement, to discuss HIV screening with the child's physician and to obtain the screening if the child's physician indicates that screening is appropriate. The parent can then provide the agency with the results of the screening before a relinquishment is signed. The parent may also allow the adoption agency to directly obtain the HIV screening results by authorizing the physician, in writing, to disclose the results directly to the adoption agency. The HIV screening results become a part of the medical background information of the child which is required by current regulations to complete the assessment of the child.

Adoption agencies should also recommend to both the adoptive petitioners and the birth parents that the child's physician be consulted regarding HIV screening, when a child from a high risk category is placed directly with the adoptive petitioners by the birth parent in an "independent" adoption. The child's physician can discuss the suitability of HIV screening with the adoptive petitioner and the birth parents and also discuss the results if the screening is performed and the necessary written authorization is obtained.

A dependent child of the court who is in a high risk category and has been referred by the court for adoption planning and placement may have HIV screening performed in a manner consistent with other court dependent children.

Agencies should review the known background information of a child who is to be placed out of home in foster care or for adoption to determine whether or not the child is at increased risk for infection by HIV. If it appears that the child is at increased risk for infection by HIV, the child's physician should be given the background information so that the physician is able to decide whether or not to refer the child for HIV screening by considering the child's high risk background and the child's other medical information.

The CDC identifies the population at increased risk of infection by HIV as homosexual/bisexual men, intravenous drug abusers, persons transfused with contaminated blood or blood products (the California Office of AIDS indicates this pertains to blood transfusions received between 1977 and 1985), and persons who have any sexual contacts with persons with HIV infection. With

respect to children, the CDC states that the pediatric AIDS cases reported to their agency include children who acquired AIDS from their mother before, during or shortly after birth when the mother was infected by HIV, or through contaminated blood or blood products.

For those children who test positive for the HIV virus, the prospective foster or adoptive parent must be advised of the test results and of the confidentiality of this information. Should the parent decide to accept the child, the social worker must provide the name of the child's physician and information outlining the necessary precautions that must be followed to prevent further transmission of HIV and to safeguard the child from opportunistic infections.

Review of the attached CDC report will assist agencies with the development of guidelines which should apply to children who are at increased risk of becoming infected with HIV and are at increased risk of developing AIDS.

While the guidelines provide sound advice on the necessary precautions to be utilized when caring for or supervising an infected child, at this time, we request that agencies ensure that any person overseeing the care and supervision of children who fall within the high risk group criteria for screening also rely upon instructions provided by the child's physician.

For County Welfare Departments (CWDs), any questions about AB 1951 in relation to court procedures or process should be directed to your local County Counsel. If you have any CWS Program questions, please contact your Adult and Family Services Operations consultant at (916) 445-0623 or ATSS 485-0623. Adoption Agencies, please direct your questions to your Adoption Policy consultant at (916) 322-4228 or ATSS 492-4228.

LOREN D. SUTER
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Adult and Family Services

Attachment

cc: County Welfare Directors Association

VII. MATERNAL AND CHILD HEALTH

1985 Aug 30;34:517–21

Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus

The information and recommendations contained in this document were developed and compiled by CDC in consultation with individuals appointed by their organizations to represent the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officers, the National Association of County Health Officers, the Division of Maternal and Child Health (Health Resources and Services Administration), the National Association for Elementary School Principals, the National Association of State School Nurse Consultants, the National Congress of Parents and Teachers, and the Children's Aid Society. The consultants also included the mother of a child with acquired immunodeficiency syndrome (AIDS), a legal advisor to a state education department, and several pediatricians who are experts in the field of pediatric AIDS. This document is made available to assist state and local health and education departments in developing guidelines for their particular situations and locations.

These recommendations apply to all children known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV). This includes children with AIDS as defined for reporting purposes (Table 1); children who are diagnosed by their physicians as having an illness due to infection with HTLV-III/LAV but who do not meet the case definition; and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III/LAV. These recommendations do not apply to siblings of infected children unless they are also infected.

BACKGROUND

The Scope of the Problem. As of August 20, 1985, 183 of the 12,599 reported cases of AIDS in the United States were among children under 18 years of age. This number is expected to double in the next year. Children with AIDS have been reported from 23 states, the District of Columbia, and Puerto Rico, with 75% residing in New York, California, Florida, and New Jersey.

The 183 AIDS patients reported to CDC represent only the most severe form of HTLV-III/LAV infection, i.e., those children who develop opportunistic infections or malignancies (Table 1). As in adults with HTLV-III/LAV infection, many infected children may have milder illness or may be asymptomatic.

Legal Issues. Among the legal issues to be considered in forming guidelines for the education and foster care of HTLV-III/LAV-infected children are the civil rights aspects of public school attendance, the protections for handicapped children under 20 U.S.C. 1401 et seq. and 29 U.S.C. 794, the confidentiality of a student's school record under state laws and under 20 U.S.C. 1232g, and employee right-to-know statutes for public employees in some states.

TABLE 1. Provisional case definition for acquired immunodeficiency syndrome (AIDS) surveillance of children

For the limited purposes of epidemiologic surveillance, CDC defines a case of pediatric acquired immunodeficiency syndrome (AIDS) as a child who has had:

1. A reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency, and
2. No known cause of underlying cellular immunodeficiency or any other reduced resistance reported to be associated with that disease

The diseases accepted as sufficiently indicative of underlying cellular immunodeficiency are the same as those used in defining AIDS in adults. In the absence of these opportunistic diseases, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis will be considered indicative of AIDS unless test(s) for HTLV-III/LAV are negative. Congenital infections, e.g., toxoplasmosis or herpes simplex virus infection in the first month after birth or cytomegalovirus infection in the first 6 months after birth must be exluded.

Specific conditions that must be excluded in a child are:

1. Primary immunodeficiency diseases—severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia, or hypogammaglobulinemia with raised IgM.
2. Secondary immunodeficiency associated with immunosuppressive therapy, lymphoreticular malignancy, or starvation.

Confidentiality Issues. The diagnosis of AIDS or associated illnesses evokes much fear from others in contact with the patient and may evoke suspicion of life styles that may not be acceptable to some persons. Parents of HTLV-III/LAV-infected children should be aware of the potential for social isolation should the child's condition become known to others in the care or educational setting. School, day-care, and social service personnel and others involved in educating and caring for these children should be sensitive to the need for confidentiality and the right to privacy in these cases.

ASSESSMENT OF RISKS

Risk Factors for Acquiring HTLV-III/LAV Infection and Transmission. In adults and adolescents, HLTV-III/LAV is transmitted primarily through sexual contact (homosexual or heterosexual) and through parenteral exposure to infected blood or blood products. HTLV-III/LAV has been isolated from blood, semen, saliva, and tears but transmission has not been documented from saliva and tears. Adults at increased risk for acquiring HTLV-III/LAV include homosexual/bisexual men, intravenous drug abusers, persons transfused with contaminated blood or blood products, and sexual contacts of persons with HTLV-III/LAV infection or in groups at increased risk for infection.

The majority of infected children acquire the virus from their infected mothers in the perinatal period (*1-4*). In utero or intrapartum transmission are likely, and one child reported from Australia apparently acquired the virus postnatally, possibly from ingestion of breast milk (*5*). Children may also become infected through transfusion of blood or blood products that contain the virus. Seventy percent of the pediatric cases reported to CDC occurred among children whose parent had AIDS or was a member of a group at increased risk of acquiring HTLV-III/LAV infection; 20% of the cases occurred among children who had received blood or blood products; and for 10%, investigations are incomplete.

Risk of Transmission in the School, Day-Care or Foster-Care Setting. None of the identified cases of HTLV-III/LAV infection in the United States are known to have been transmitted in the school, day-care, or foster-care setting or through other casual person-to-person contact. Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the over 12,000 AIDS patients reported to CDC have been reported to have AIDS. Six studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to older children who were not likely at risk from perinatal transmission (*6-11*).

Based on current evidence, casual person-to-person contact as would occur among schoolchildren appears to pose no risk. However, studies of the risk of transmission through contact between younger children and neurologically handicapped children who lack control of their body secretions are very limited. Based on experience with other communicable diseases, a theoretical potential for transmission would be greatest among these children. It should be emphasized that any theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes to blood and possibly other body fluids of an infected person.

Risks to the Child with HTLV-III/LAV Infection. HTLV-III/LAV infection may result in immunodeficiency. Such children may have a greater risk of encountering infectious agents in a school or day-care setting than at home. Foster homes with multiple children may also increase the risk. In addition, younger children and neurologically handicapped children who may display behaviors such as mouthing of toys would be expected to be at greater risk for acquiring infections. Immunodepressed children are also at greater risk of suffering severe complications from such infections as chickenpox, cytomegalovirus, tuberculosis, herpes simplex, and measles. Assessment of the risk to the immunodepressed child is best made by the child's physician who is aware of the child's immune status. The risk of acquiring some infections, such as chickenpox, may be reduced by prompt use of specific immune globulin following a known exposure.

RECOMMENDATIONS

1. Decisions regarding the type of educational and care setting for HTLV-III/LAV-infected children should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the team approach including the child's physician, public health personnel, the child's parent or guardian, and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed.
2. For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and

the apparent nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting.

3. For the infected preschool-aged child and for some neurologically handicapped children who lack control of their body secretions or who display behavior, such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with HTLV-III/LAV should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.
4. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's HTLV-III/LAV infection and the modes of possible transmission. In any setting involving an HTLV-III/LAV-infected person, good handwashing after exposure to blood and body fluids and before caring for another child should be observed, and gloves should be worn if open lesions are present on the caretaker's hands. Any open lesions on the infected person should also be covered.
5. Because other infections in addition to HTLV-III LAV can be present in blood or body fluids, all schools and day-care facilities, regardless of whether children with HTLV-III. LAV infection are attending, should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants, such as household bleach (diluted 1 part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible, and mops should be rinsed in the disinfectant. Those who are cleaning should avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.
6. The hygienic practices of children with HTLV-III/LAV infection may improve as the child matures. Alternatively, the hygienic practices may deteriorate if the child's condition worsens. Evaluation to assess the need for a restricted environment should be performed regularly.
7. Physicians caring for children born to mothers with AIDS or at increased risk of acquiring HTLV-III/LAV infection should consider testing the children for evidence of HTLV-III/LAV infection for medical reasons. For example, vaccination of infected children with live virus vaccines, such as the measles-mumps-rubella vaccine (MMR), may be hazardous. These children also need to be followed closely for problems with growth and development and given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella. In the event that an antiviral agent or other therapy for HTLV-III/LAV infection becomes available, these children should be considered for such therapy. Knowledge that a child is infected will allow parents and other caretakers to take precautions when exposed to the blood and body fluids of the child.
8. Adoption and foster-care agencies should consider adding HTLV-III/LAV screening to their routine medical evaluations of children at increased risk of infection before placement in the foster or adoptive home, since these parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families.
9. Mandatory screening as a condition for school entry is not warranted based on available data.
10. Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).
11. All educational and public health departments, regardless of whether HTLV-III/LAV-infected children are involved, are strongly encouraged to inform parents, children, and educators regarding HTLV-III/LAV and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others.

References

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